## Process Related Events Report form

This audit is for Continuous Quality Improvement Peer Review Committee purposes. The information contained is confidential.

**TO: Peer Review Consultant & Committee**

On the date shown I/we conducted an audit of prescriptions filled as a measure of quality. I/we corrected any prescriptions found incorrect, noted the error(s) and noted the number of new and refilled prescriptions for the day. As a result of this audit, I/we found the following:

### Quality Related Event (QRE)

<table>
<thead>
<tr>
<th>New Rx</th>
<th>Refill Rx</th>
<th>Where was the QRE caught?</th>
<th>What type of QRE was made?</th>
<th>Where was the QRE made?</th>
<th>Received by patient?</th>
<th>What time was QRE made?</th>
<th>Pharmacy Notes: What happened and why May also note any steps that will be taken to avoid future incidents</th>
<th>Drug(s) Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>1</td>
<td>B</td>
<td>12</td>
<td>No</td>
<td></td>
<td></td>
<td>EXAMPLE DATA ----- Pulled incorrect stock bottle from shelf; We decided to emphasize NDC check</td>
<td>Warfarin 2.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prescribed</td>
<td>Warfarin 5</td>
</tr>
</tbody>
</table>

### New Rx

- [A] Incorrect Drug
- [B] Incorrect Strength
- [C] Incorrect Directions
- [D] Failure to Counsel
- [E] Refill Incorrect
- [G] Generic Substitution
- [H] Incorrect Quantity
- [I] Incorrect Prescriber
- [K] Safety cap
- [L] Confidentiality
- [O] Other (explain)
- [P] Failure in Drug Review
- [Q] Order Mix up

### Refill Rx

- [A] Incorrect Drug
- [B] Incorrect Strength
- [C] Incorrect Directions
- [D] Failure to Counsel
- [E] Refill Incorrect
- [G] Generic Substitution
- [H] Incorrect Quantity
- [I] Incorrect Prescriber
- [K] Safety cap
- [L] Confidentiality
- [O] Other (explain)
- [P] Failure in Drug Review
- [Q] Order Mix up

### Where in the process was the QRE made?

- [1] Final Pharmacist check
- [2] Partner check
- [4] Patient Discovery
- [5] Other
- [6] Entry
- [7] Filling
- [8] Counseling
- [9] Delivery
- [18] Order Mix-up
- [19] Other
- [20] Filling Process
- [21] Selected incorrect drug
- [22] Selected incorrect strength
- [23] Placed incorrect label on container
- [24] Incorrect quantity
- [25] Order mix up
- [26] Safety cap/easy open requested
- [27] Missing or inappropriate auxiliary labels
- [28] Pharmacist Drug review
- [29] Clarification

### Example Data

--- Pulled incorrect stock bottle from shelf; We decided to emphasize NDC check

--- Warfarin 2.5

--- Warfarin 5

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